



Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747, Boston, MA 02114

altus dentalTM
Altus Dental Insurance Company, Inc.



Retiree Dental Program Enrollment and Change Form

PLEASE TYPE OR PRINT CLEARLY

01

Insured's GIC-ID — —	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth ____/____/____	Dept. ID # or Agency/Division # —
Name: Last _____ First _____ M.I. _____			
Address (Number and Street) _____ This is a new Address: <input type="checkbox"/>			
City	State	Zip Code	Home Phone No.

02

NEW ENROLLMENT ☐ CHANGE ☐ CANCEL COVERAGE ☐

Effective Date:

Type of Coverage: Individual ☐ Family ☐

PLEASE READ CAREFULLY: Important Coverage and Eligibility Notes

1. If you don't sign up for coverage when you are first eligible, you will not be able to enroll until the next annual enrollment period.
2. The only time you can change your coverage is during the annual enrollment period, **unless** there is a qualifying event such as marriage, divorce or death.
3. If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin. If you sign up for individual or family coverage and decide to cancel, you can never rejoin the plan.

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ NEW MEMBER ☐ ADDITION ☐ DELETION ☐ CORRECTION

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. Attach separate sheet if additional space is required.

The Group Insurance Commission reserves the right to require you to provide a copy of a marriage certificate, birth certificate, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. This proof may be requested at any time.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number
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Reason for addition or deletion: _____

Effective date: _____

Deduction and Coverage Authorization: I authorize my pension authority to deduct from my pension check the amount required for the dental coverage I have selected. I have read and understood the "Important Coverage and Eligibility Notes" above.

X _____

Signature of Applicant

Date

FOR GIC USE ONLY

Certificate #	Cross Ref. #	Political Subdivision	
Entered	Verified		